Appendix D: Service Authorization for DD Waiver Services

Last Updated: 05/10/2022

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Updated 5/10/2022

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General Information Chapter for Service Authorization - INTRODUCTION

Service authorization (SA) is the process to approve specific services for an enrolled Medicaid individual.

Service authorization must occur prior to service delivery (other than crisis services) and reimbursement.

Purpose of Service Authorization

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid/FAMIS eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity. Medallion 3 MCO-enrolled members are subject to service authorization requirements of the individual's MCO.

General Information Regarding Service Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for Srv Auth requests.

The Srv Auth entity will approve, pend, reject, or deny all completed Srv Auth requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care (MCO) program, the Srv Auth entity will honor the Medicaid MCO service authorization if the client has been retroactively disenrolled from the MCO. Similarly, the MCO will honor the Srv Auth Contractor's authorization based upon proof of authorization from the provider, DMAS, or the Srv Auth Contractor that services were authorized while the member was eligible under fee- for-service (not MCO enrolled) for dates where the member has subsequently become enrolled with a DMAS contracted MCO Srv Auth decisions by the DMAS Srv Auth Contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested. The Srv Auth Contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify member eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled members, the provider must follow the MCO's Srv Auth policy and billing guidelines.

Commonwealth Coordinated Care (IFDD)

Commonwealth Coordinated Care is a program where members who have full Medicare and Medicaid benefits and meet all eligibility criteria are able to receive coordinated care through a managed care environment. The program objective is to coordinate delivery of primary, preventive, acute, behavioral, and long-term care services and supports.

CCC services do not cover the following waivers: Tech Waiver, DD Waiver, ID Waiver, Day Support, and Alzheimer Waivers. If a member becomes eligible for or receives a slot in one of these CCC excluded waivers, the member will be enrolled in the Waiver and may begin receiving Waiver services. CCC will continue to cover the regular medical services until the end of the month. The member will be automatically disenrolled from CCC the last day of that month. The member will receive all services through fee-for-service Medicaid or Medicare effective the first day of the next month. The DMAS service authorization contractor will process the service authorization request for the specific waivers/services listed for members dually enrolled in CCC. The request must include all the required documentation for a complete service authorization review. Providers will need to adhere to the timeliness requirements for new admission requests.

Communication (IFDD)

Provider manuals are located on the DMAS Web Portal and KEPRO website. The contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to http://dmas.kepro.com. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Waiver* tab.

The Srv Auth entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of-hearing.

Updates or changes to the Srv Auth process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS Web Portal. Changes will be incorporated within the manual.

Service Authorization for Waiver Services (IFDD)

General Information

Prior to requesting authorization of services under the waivers, the individual must be deemed Medicaid eligible by the Department of Social Services and meet waiver criteria. Criteria for enrollment differs from waiver to waiver. The following chart indicates the Srv Auth entity that will accept requests for enrollment, and the alternate institutional placement. It is important to note that an individual can only be enrolled in one waiver at a time; if transferring from one waiver to another, there cannot be overlaps in dates. Please see Chapter IV for enrollment processes.

Waiver	**Send Enrollment To**	**Alternate Institutional Placement**
Elderly or Disabled with Consumer Direction (EDCD) Waiver	KEPRO	Skilled Nursing Facility
Individual and Family Developmental Disabilities Support (IFDDS)Waiver	DBHDS	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Technology Assisted (Tech) Waiver	DMAS	Skilled Nursing Facility or Acute Hospital
Intellectual Disability (ID) Waiver (formerly Mental Retardation Waiver)	DBHDS	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Day Support (DS) Waiver for Individuals with Intellectual Disability	DBHDS	Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)
Alzheimer's Assisted Living (AAL)Waiver	KEPRO	Skilled Nursing Facility

DD Waiver Services Requiring Authorization

(All requests must be approved through DBHDS on the Plan of Care prior to submitting to Srv Auth Contractor.)

IFDDS Waiver Services

Service Definition	Procedure Code	Documentation Required for Service Authorization
Therapeutic Consultation	97139	Documentation of at least one other qualifying Waiver service currently authorized. Service must be approved on the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

Day Support - Regular, Center or Non-Center Based	97537	Service must be approved on the DMAS DD POC. 780 units per POC year maximum, either as a stand-alone service, or in combination with Supported Employment and/or Pre- Vocational Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Day Support - High Intensity, Center or Non-Center Based	97537 U1	Service must be approved on the DMAS DD POC. 780 units per POC year maximum, either as a stand-alone service, or in combination with Supported Employment and/or Pre- Vocational Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Crisis Stabilization – Supervision	H0040	Service must be approved on the DBHDS DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is up to 15 consecutive days; up to 4 authorizations annually (annual total 60 days), and in accordance with Plan's effective from and through dates.
Crisis Stabilization - Intervention	H2011	Service must be approved on the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is 15 consecutive days; up to 4 authorizations annually (annual total 60 days).

In-Home Residential Support	H2014	Documentation of the name of the In-Home Residential Support direct care staff and the relationship to the Member. This is not the name of the Provider agency. Service must be approved on the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Personal Emergency Response System - Installation	S5160	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Service must be approved on the DMAS DD POC. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. Must be requested with S5161, PERS Monthly Monitoring.

		Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.

Personal Emergency Response System - Installation (with medication monitoring)	S5160, U1	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Service must be approved on the DMAS DD POC. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. Must be requested with S5185, PERS and Medication Monthly Monitoring, and PERS Nursing (H2021 TD or H2021 TE) Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.
PERS Monthly Monitoring	S5161	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Documentation of a previous PERS installation (i.e. through private pay) if monitoring request is not accompanied by a request for the installation OR the individual does not have an existing authorization for a PERS installation (S5160). Service must be approved on the DMAS DD POC. PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

PERS Monthly Monitoring with Medication	S5185	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Documentation of a previous PERS and medication monitoring installation (i.e. through private pay) if monitoring request is not accompanied by a request for the installation OR the individual does not have an existing authorization for a PERS installation (S5160 U1). Service must be approved on the DMAS DD POC. Must be requested with PERS Nursing (H2021 TD or H2021 TE). PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care.

		Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

PERS Nursing, RN	H2021, TD	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Documentation of a previous PERS and medication monitoring installation (i.e. through private pay) if monitoring request is not accompanied by a request for the installation OR the individual does not have an existing authorization for a PERS installation. Service must be approved on the DMAS DD POC. Must be requested with or already authorized for S5185 (PERS and Medication Monitoring). PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

PERS Nursing LPN	H2021, TE	Documentation of at least one other qualifying Waiver service currently authorized. (PERS cannot be a sole service). Documentation of a previous PERS and medication monitoring installation (i.e. through private pay) if monitoring request is not accompanied by a request for the installation OR the individual does not have an existing authorization for a PERS installation. Service must be approved on the DMAS DD POC. Must be requested with or already authorized for S5185 (PERS and Medication Monitoring). PERS cannot be authorized for individuals who have Supervision currently authorized as a component of Personal Care. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Supported Employment - Individual	H2023	Service must be approved on the DMAS DD POC. 2080 units per POC year maximum, either as a stand-alone service, or in combination with Prevocational and/or Day Support Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

Supported Employment - Enclave (Group)	H2024	Service must be approved on the DMAS DD POC. 780 units per POC year maximum, either as a stand-alone service, or in combination with Prevocational and/or Day Support Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Pre-Vocational Services- Regular Intensity	H2025	Service must be approved on the DMAS DD POC. 780 units per POC year maximum, either as a stand-alone service, or in combination with Supported Employment and/or Day Support Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Pre-Vocational Services - High Intensity	H2025 U1	Service must be approved on the DMAS DD POC. 780 units per POC year maximum, either as a stand-alone service, or in combination with Supported Employment and/or Day Support Services. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

Family Caregiver Training	S5111	Documentation of name and title of the professional providing the training, and the name of the individual being trained and their relationship to the Medicaid Member. Documentation of at least one other qualifying Waiver service currently authorized. Service must be approved on the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Personal Care Services, Agency	T1019	Service must be approved on the DMAS DD POC. For readmissions post discharge or transfer to a new Provider, documentation submitted must include the following: DMAS 99: The signature date must be on or before the new start of care date (cannot approve prior to sign date), Functional status, diagnoses, current medication list, current health status, current medical nursing needs, current therapies and/or special medical procedures, current waiver services currently receiving, name of the personal care aide/attendant, weekly hours attendant will provide care, specific hours the attendant is in the home, name of the unpaid

		primary caregiver and relationship to member, if Primary Caregiver (PCG) resides with the member, type of care provided by PCG, if member receives PERS, is individual is in need of PERS or Supervision. Aides/Attendants cannot be the parents of minor individuals receiving services, or the spouse of the individual receiving services. Attendants cannot be the family/caregivers that are directing the individuals care. When the individual is readmitted or transfers to another provider and the hours are not changing and remain within cap, there is no need to submit a plan of care (DMAS 97A/B), however the date the new plan of care was completed must be documented with the Service Authorization (SA) submission to KEPRO. If there is an increase or decrease in hours from the previous authorization/Provider, information from the new POC (DMAS 97A/B) and justification for the change in hours is required for review. Documentation from the POC required as follows: DMAS 97 A/B: POC breakdown of hours per day; ADL composite score, back up plan, POC effective and signature date. DMAS100 (If supervision being requested): Cognitive status, physical incapacity, ability to call via telephone for help, unstable medical conditions, seizures, current support system (does PCG live with member, does PCG work outside of the home - including hours of work schedule to include travel time, and times the attendant is in the home), listing of current support system/back-up for when attendant is absent from the home. **All forms listed above must be uploaded in Atrezzo.** Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates

Personal Care Services - Consumer Directed	S5126	Documentation of the name of person directing the care and relationship to the member, name of the attendant providing the care and relationship to the member (DMAS 99). Approval may not be granted for services rendered by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide care. Service must be approved on the DMAS DD POC.

		For readmissions post discharge or transfer to a new Provider, documentation submitted must include the following: DMAS 99: The signature date must be on or before the new start of care date (cannot approve prior to sign date), Functional status, diagnoses, current medication list, current health status, current medical nursing needs, current therapies and/or special medical procedures, current waiver services currently receiving, name of the personal care aide/attendant ,weekly hours attendant will provide care, specific hours the attendant is in the home, name of the unpaid primary caregiver and relationship to member, if Primary Caregiver (PCG) resides with the member, type of care provided by PCG, if member receives PERS, is individual is in need of PERS or Supervision. Aides/Attendants cannot be the parents of minor individuals receiving services, or the spouse of the individual receiving services. Attendants cannot be the family/caregivers that are directing the individual's care. When the individual is readmitted or transfers to another provider and the hours are not changing and remain within cap, there is no need to submit a plan of care (DMAS 97A/B), however the date the new plan of care was completed must be documented with the Service Authorization (SA) submission to KEPRO. If there is an increase or decrease in hours from the previous authorization/Provider, information from the new POC (DMAS 97A/B) and justification for the change in hours is required for review. Documentation from the POC required as follows: DMAS 97 A/B: POC breakdown of hours per day; ADL composite score, back up plan, POC effective and signature date. DMAS100 (If supervision being requested): Cognitive status, physical incapacity, ability to call via telephone for help, unstable medical conditions, seizures, current support system (does PCG live with member, does PCG work outside of the home- including hours of work schedule to include travel time, and times the attendant is in the home), listing of current support system/back-up for when attendant is absent from the home. **All forms listed above must be uploaded in Atrezzo.** Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

Respite Care-	T1005	Documentation of the name of the unpaid Primary Caregiver.

Services Agency	(RESPI)	Service must be approved on the DMAS DD POC. For readmissions post discharge or transfer to a new Provider: Documentation must include the date of the most recent DMAS 99 (assessment). Approval may not be granted for services rendered by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide care. Aides/Attendants cannot be the parents of minor individuals receiving services, or the spouse of the individual receiving services. Attendants cannot be the family/caregivers that are directing the individuals care. Effective April 1, 2014, the maximum service authorization duration is up to 24 months, and in accordance with Plan's effective from and through dates Respite must be included on the annual plan to receive funding for the next year; however service authorization does not have to be requested from the service authorization contractor until 30 Days prior to the current authorization ending. **All forms listed above must be uploaded in Atrezzo.** A maximum of up to 480 hrs. may be authorized per plan year.

Respite Care - Consumer Directed	S5150	Documentation of the name of the unpaid Primary Caregiver, name of person directing the care and relationship to the member, and the name of the person providing the care and relationship to the Member. (DMAS 99) Service must be approved on the DMAS DD POC. For readmissions post discharge or transfer to a new Provider: Documentation must include the date of the most recent DMAS 99 (assessment). Approval may not be granted for services rendered by other family members who live under the same roof as the individual, unless there is objective written documentation as to why there are no other providers available to provide care. Aides/Attendants cannot be the parents of minor individuals receiving services, or the spouse of the individual receiving services. Attendants cannot be the family/caregivers that are

		directing the individuals care. Effective April 1, 2014, the maximum service authorization duration is up to 24 months, and in accordance with Plan's effective from and through dates. Respite must be included on the annual plan to receive funding for the next year; however service authorization does not have to be requested from the service authorization contractor until 30 Days prior the current authorization ending. **All forms listed above must be uploaded in Atrezzo.** A maximum of up to 480 hrs. may be authorized per plan year.
Skilled Nursing, RN	T1002	Documentation of the Physician's signature date on the CMS 485 and the effective start of care date of the physician's order. (Services cannot be approved prior to the physician's signature date). Service must be approved on the DMAS DD POC. Service may be authorized for up to 6 months per request in accordance with the date range covered by the CMS 485 and the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.
Skilled Nursing, LPN	T1003	Documentation of the Physician's signature date on the CMS 485 and the effective start of care date of the physician's order. (Services cannot be approved prior to the physician's signature date). Service must be approved on the DMAS DD POC. Service may be authorized for up to 6 months per request in accordance with the date range covered by the CMS 485 and the DMAS DD POC. Effective January 1, 2013, the maximum service authorization duration is 12 up to months.

Transition Services	T2038	DBHDS **FUNCTION ONLY**: The IFDDS Case Manager must submit requests for Transition Services directly to the DBHDS Healthcare Coordinator for authorization. Effective January 1, 2013, the maximum service authorization duration is up to 9 months, and in accordance with Plan's effective from and through dates.

		The maximum Medicaid funded expenditure is $5000.00 per individual lifetime.
Assistive Technology	T1999	Documentation of at least one other qualifying Waiver service currently authorized. Actual cost of item requested must be included with request (wholesale cost). Service must be approved on the DMAS DD POC. The maximum Medicaid funded expenditure is $5000.00 per plan year. Dates of service authorized cannot crossover the calendar or DD POC year. Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.

Assistive Technology, Maintenance	T1999, U5	Documentation of at least one other qualifying Waiver service currently authorized. Actual cost of item requested must be included with request (wholesale cost). Service must be approved on the DMAS DD POC. The maximum Medicaid funded expenditure is $5000.00 per plan year. Dates of service authorized cannot crossover the DD POC year. Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.
Environmental Modifications, Structural	S5165	Documentation of at least one other qualifying Waiver service currently authorized. Service must be approved on the DMAS DD POC. The maximum Medicaid funded expenditure is $5000.00 per plan year. Dates of service authorized cannot crossover the DD POC year. Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.
Environmental Modifications, Maintenance	99199, U4	Documentation of at least one other qualifying Waiver service currently authorized. Service must be approved on the DMAS DD POC. The maximum Medicaid funded expenditure is $5000.00 per plan year. Dates of service authorized cannot crossover the calendar or DD POC year.

		Effective January 1, 2013, the maximum service authorization duration is up to 30 days, and in accordance with Plan's effective from and through dates.
Companion Care - Agency	S5135	Service must be approved on the DMAS DD POC. Companion Care (CC) is limited to 2080 hours per POC year for both types of CC combined. Note: CC is not authorized for persons whose only need for CC is for assistance exiting the home in the event of an emergency and/or socialization. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates..
Companion Care - Consumer Directed	S5136	Service must be approved on the DMAS DD POC. Companion Care (CC) is limited to 2080 hours per POC year for both types of CC combined. Note: CC is not authorized for persons whose only need for CC is for assistance exiting the home in the event of an emergency and/or socialization. Effective January 1, 2013, the maximum service authorization duration is up to 12 months, and in accordance with Plan's effective from and through dates.

Service Authorization for IFDDS Waiver Services

After the Case Manager obtains confirmation of enrollment by DBHDS, they must assure that the contractor receives the current approved Plan of Care (DMAS 456) prior to submitting requests for service. All services identified on the DMAS 456 must be approved by DBHDS as evidenced by the Health Care Coordinators signature and date.

Services are not authorized retroactively, unless specifically indicated within Chapter IV.

The MMIS generates letters to providers, case managers, and enrolled individuals depending on the final determination.

DMAS will not reimburse providers for dates of service prior to the date authorized on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during Quality Management Review (QMR) and/or post payment audit.

All service requests must be submitted through the Case Manager. For IFDDS service requests, only Consumer Directed (CD) services, Personal Care (including Supervision), Companion Care, Crisis Stabilization, and Respite Care can be authorized retroactively with a start of care (SOC) date prior to the date the Srv Auth Contractor receives request (and only if approved by DBHDS on the POC retroactively). All **other** services may be approved with a start of care on or after the date the request was submitted to the Srv Auth Contractor (regardless of when approved by DBHDS on the POC).

Plans of Care and Service Authorizations

Service requests revolve around the POC date. Upon initial enrollment to the DD Waiver, services must begin within 60 days or an extension letter, approved by a DMAS Health Care Coordinator, must be obtained and sent to the contractor. (See Chapter IV for more details on extension letters.) All POCs must be reviewed, signed and dated by the enrolled individual indicating agreement to the POC.

Plans of care must be renewed annually. If the POC is not renewed prior to the last date in the previously approved year, the service(s) will be ended and will not be reinstated until a renewal plan is received by the contractor.

Plan revisions are necessary when there has been a change in the amount of an existing service, or a service has added or terminated from the individuals plan. If adding a service, the POC revision must be approved by DBHDS, sent to the contractor, then the request for the additional service made.

Submitting Requests for Service Authorization

Service Authorization reviews will be performed by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO). All submission methods and procedures are fully compliant with the Health Insurance Portability and

Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests submitted to KEPRO.

There are no automatic renewals of service authorizations. Providers must submit a service authorization request if a member requires continued services or the current authorization will end without renewal.

KEPRO accepts service authorization (srv auth) requests through direct data entry (DDE), fax, phone and US mail. The preferred method is by DDE through KEPRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KEPRO's website, go to http://dmas.kepro.com. For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

Provider Registration is Required to use Atrezzo Connect

The registration process for providers happens immediately on-line. From http://dmas.kepro.com, providers not already registered with Atrezzo Connect may click on the Atrezzo icon on the website to register. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent remittance advice date for YTD 1099 amount.

The Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, then the *General* tab.

Providers with questions about KEPRO's Atrezzo Connect Provider Portal may contact KEPRO by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KEPRO at providerissues@kepro.com. KEPRO may also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

KEPRO's website has information related to the service authorization processes for all Medicaid programs they review. Fax forms, service authorization checklists, trainings, methods of submission and much more are on KEPRO's website. Providers may access this information by going to http://dmas.kepro.com.

Processing Requests at KEPRO:

KEPRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached KEPRO notifies the member and the provider in writing of the status of the request through the MMIS letter generation process.

If there is insufficient information to make a final determination, KEPRO will pend the request back to the provider and request additional information. If the information is not received within the time frame requested by KEPRO, the request will automatically

be sent to a physician for a final determination with all information that has been submitted. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

If services cannot be approved for members under the age of 21 using the current criteria, KEPRO will then review the request by applying EPSDT criteria.

The MMIS generates letters to providers, case managers, and members depending on the final determination. DMAS will not reimburse providers for dates of service prior to the date(s) identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during post payment review. Please see additional requirements in Chapter VI of this manual.

The following documentation is required in order to determine if the individual meets criteria:

(1) Certificate of Medical Necessity (CMN), unless items meet exception criteria stated in Chapter IV; (2) Supporting documentation verifying item specific coverage criteria stated in Chapter IV; and (3) Documentation of usual and customary charges or cost as necessary for each HCPCS code used from Appendix B.

All items and supplies must meet the coverage criteria in Chapter IV of this manual and the Virginia Administrative Code. In addition, DMAS requires specific categories of items meet the InterQual criteria. These categories are: adaptive strollers, nebulizers (including compressors), augmentative communication devices (AAC and speech generating devices), continuous passive motion devices, cranial molding orthosis, oxygen, hospital beds, insulin pumps, lower extremity orthosis (knee braces and immobilizers), lymphedema compression devices, manual wheelchairs, negative pressure wound therapy devices, CPAP and BiPAP devices, power wheelchairs and scooters, seat lift mechanisms (not lift chairs), secretion clearance devices, standing frames, support surfaces, TENS, wheelchair cushions and seating systems.

The above list is subject to change with InterQual updates and DMAS discretion.

- The medical justification provided to the Service Authorization Contractor must meet the DME InterQual Criteria upon review. These criteria may be obtained through:

McKesson Health Solutions LLC

275 Grove Street

Suite 1-110

Newton, MA 02466-2273

Telephone: 800-274-8374

Fax: 617-273-3777

Website: www.mckesson.com or www.InterQual.com

Subsequent Recertification Review

Prior to the end of the last authorized date, the provider should submit the required documents for continued service authorization. The documentation will be reviewed to determine if it meets DMAS criteria and documentation requirements found in Chapters IV and VI of this manual, including the practitioner's signature and date on the certificate of medical necessity. The DMAS service authorization contractor will make a decision to approve, pend, deny, or reject the request. If approved, the service authorization contractor will authorize a specific number of units and dates of service based on the documentation submitted.

How to Determine if Services Require Service Authorization

In order to determine if services need to be service authorized, providers should go to the DMAS website: http://dmasva.dmas.virginia.gov and look to the right of the page and click on the section that says Procedure Fee Files which will then bring you to this: http://www.dmas.virginia.gov/pr-fee_files.htm. You will now see a page entitled DMAS Procedure Fee Files. The information provided there will help to determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

To determine if a service needs Service Authorization, next determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version. The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

00 – No PA is required

01 – Always needs a PA

02 -Only needs PA if service limits are exceeded

03- Always need PA, with per frequency.

To determine whether a service is covered by DMAS you need to access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides you special coverage and/or payment information. A Procedure Flag of "999" indicates that a service is non-covered by DMAS.

Early Periodic Screening Diagnosis and Treatment (EPSDT) Service Authorization Section (IFDD)

The EPSDT service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible, before the problem becomes complex and treatment more costly. Examination and treatment services are provided at no cost to the individual.

Any treatment service which is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by DMAS or a DMAS-contracted managed care organization as medically necessary. Therefore, services may be approved for persons under the age of 21 enrolled in Medicaid, FAMIS Plus and FAMIS Fee For Service (FFS) if the service/item is physician ordered and is medically necessary to correct, ameliorate (make better) or maintain the individual's condition. (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).

All Medicaid and FAMIS Plus services that are currently service authorized by the Srv Auth contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information

regarding the methods of submission may be found at the contractor's website, http://DMASKEPRO.com. Click on Virginia Medicaid. They may also be reached by phone at 888- 827-2884 or 804-622-8900.

EPSDT is not a specific Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria (service/item is physician ordered and is medically necessary to correct, ameliorate "make better" or maintain the individual's condition) must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all service authorization reviews of service authorized Medicaid services. Service requests that are part of a community based waiver are the sole exception to this policy. Waivers are exempt from EPSDT criteria because the federal approval for waivers is strictly defined by the state. The waiver program is defined outside the parameters of EPSDT according to regulations for each specific waiver. However, waiver individuals may access EPSDT treatment services when the treatment service is not available as part of the waiver for which they are currently enrolled.

Examples of EPSDT Review Process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

- Another example using mental health services would be as follows: A child has been routinely hitting her siblings; the child has received 20 individualized counseling sessions and 6 family therapy sessions to address this behavior. Because the behavior has decreased, but new problematic behaviors have developed such as nighttime elopement and other dangerous physical activity, more therapy was requested for the child. The service limit was met for this service. But because there is clinical evidence from the therapy providers to continue treatment, the contractor should approve the request because there is clinically appropriate evidence which documents the need to continue therapy in a variation or continuation of the current

treatment modalities.

The review process as described is to be applied across all non-waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT program. Examples of non-covered services are inclusive of but are not limited to the following services: hearing aids, substance abuse treatment, non- waiver personal care, assistive technology, and nursing. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).